STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

MEMPHIS MANAGED CARE CORPORATION

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2003
THROUGH JUNE 30, 2003

TABLE OF CONTENTS

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DEPARTMENT OF COMMERCE AND INSURANCE
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DATE: January 13, 2005

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Memphis Managed Care Corporation, Memphis, Tennessee, was completed September 25, 2003. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Memphis Managed Care Corporation (MMCC). Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by MMCC. This report also reflects the results of a compliance examination of MMCC's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of MMCC was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement between the State of Tennessee and MMCC, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215.

MMCC is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of MMCC. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by MMCC on its National Association of Insurance Commissioners (NAIC) quarterly statement for the period ended June 30, 2003, and the Medical Fund Target Report filed by MMCC as of June 30, 2003.

The limited scope compliance examination focused on MMCC's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act, and the Insurance Holding Company Act.

Fieldwork was performed using records provided by MMCC before and during the onsite examination of records from September 15 through September 25, 2003.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that MMCC's TennCare operations were administered in accordance with the Contractor Risk Agreement and state statutes and regulations concerning HMO operations, thus reasonably assuring that the MMCC TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether MMCC met certain contractual obligations under the Contractor Risk Agreement and whether MMCC was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*.;

- Determine whether MMCC had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether MMCC properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether MMCC had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether MMCC had corrected deficiencies outlined in prior reviews of MMCC conducted by TDCI.

III. PROFILE

A. Administrative Organization

MMCC was organized as a not-for-profit corporation by its sole members, Shelby County Health Care Corporation d/b/a The Regional Medical Center at Memphis (The MED) and UT Medical Group, Inc. (UTMG). MMCC was initially organized to provide for the delivery of health care services to members of the State's TennCare Program and has participated in the program since its inception on January 1, 1994. MMCC was incorporated on July 7, 1993, and was licensed as an HMO with the state on November 24, 1993.

The officers and board of directors for MMCC at June 30, 2003, were as follows:

Officers for MMCC

Al King, President
Bruce Steinhauer, Dr., Secretary

Board of Directors for MMCC

Steven Burkett
Jeff Brandon
Al King
Andy Spooner, MD
Barry Fowler
Stuart Polly, MD
Bruce Steinhauer, MD
Brenda Jeter
Dennis Schaberg, MD

B. Brief Overview

Effective May 1, 2002, the Contractor Risk Agreement with MMCC was amended for MMCC to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. MMCC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, MMCC receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to MMCC. The TennCare Bureau reimburses MMCC for the cost of providing covered services to TennCare enrollees.

MMCC is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Shelby County, Northwest Tennessee and Southwest Tennessee which comprise the West Grand Region. All premium revenue earned by MMCC is from payments received for enrollees assigned by the TennCare Bureau.

As of June 30, 2003, MMCC reported enrollment of approximately 189,000 TennCare members.

C. Claims Processing Not Performed by MMCC

During the period under examination, MMCC subcontracted with the following vendor for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Scrip Solutions, Inc. d/b/a Scrip Pharmacy Solutions, for pharmacy.

Claims for pharmaceutical services were not included in MMCC's pool of claims from which claims were selected for testing. Therefore, except for timeliness testing, no pharmacy claims were tested as part of this exam.

It should be noted that as of July 1, 2003, MMCC was no longer contractually responsible for pharmacy benefits. The TennCare Bureau contracted directly with a single pharmacy benefits manager as of July 1, 2003, for the provision of pharmacy benefits to all TennCare enrollees.

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial and claims processing deficiencies cited in the examination by the TDCI, TennCare Division for the period January 1, 2000, through March 31, 2001:

A. Limited Scope Financial Examination

MMCC failed to correctly apply the $50,000 investment threshold per T.C.A. § 56-3-307 for investments including electronic computer or data processing machines or systems (EDP) having an original cost of at least $50,000. In addition, MMCC failed to apply Statement of Statutory Accounting Principle Number 16 which limits the aggregate amount of admitted EDP equipment and operating system software (net of accumulated depreciation) to three percent of the reporting entity's capital and surplus as shown on the statutory balance sheet of the reporting entity for its most recently filed statement, adjusted to exclude any EDP equipment and operating system software, net deferred tax assets and net positive good will. MMCC's net worth included EDP equipment and operating software that should be non-admitted; net worth was decreased by $669,813.

This finding is not repeated as part of this report.

B. Claims Processing

1. MMCC did not process claims in accordance with the prompt pay requirements.

2. Two of the 60 claims examined had procedure codes entered incorrectly.

3. Two of the 60 claims examined were denied using the incorrect denial code.

4. One of the 60 claims did not have all the lines from the claim entered into the claims processing system. This omission did not result in a mispayment of the claim.

5. One claim did not pay in accordance with the negotiated rate with the provider.

6. Of the five claims examined with co-payment responsibilities, the benefit accumulator for three claims failed to include all applicable co-payments.

Findings numbered 1 and 6 above are repeated as part of this report.

C. Other Findings and Analyses – Claims Processing

The weekly claims processing report failed to report subcontractor claim data.

This finding is not repeated as part of this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. Interest generated from deposit of funds held for provider payments are the property of the state. MMCC did not return interest earned from the deposit of state funds held for provider payments from the beginning of the non-risk period, May 1, 2002, through the examination fieldwork date. MMCC agreed to reimburse the state for previous interest earned and to reduce subsequent claims funding requests for interest earned as required by the Contractor Risk Agreement. After the completion of examination fieldwork, MMCC refunded the interest earned to the State (See Section VI.A.4.)

2. During the examination period, third party liability recoveries and subrogation amounts received which were related to the non-risk agreement period were not refunded to the state when recovered. Subsequently, MMCC has refunded to the state third party liability recoveries and subrogation amounts received related to the non-risk agreement period. (See Section VI.A.5.)

3. MMCC incorrectly recorded as cash on the 2003 NAIC Annual Statement a receivable due from the TennCare bureau of $9,684,089. The classification error did not affect MMCC's reported net worth as of June 30, 2003. (See Section VI.A.6.)

4. MMCC incorrectly included in admitted assets $17,095 in receivables from parents, subsidiaries, and affiliates over 90 days old on the June 30, 2003, Quarterly NAIC Statement. (See Section VI.A.7.)

5. MMCC's supplemental TennCare Operations Statement as of June 30, 2003, was not prepared as if MMCC were still at risk by including all income and expenses related to claims, losses, and premiums for claims as required by Section 2-10.i. of the Contractor Risk Agreement. (See Section VI.B.)

B. Claims Processing Deficiencies

1. For 29 of the 60 claims selected for testing, the difference between the date of service and the received date exceeded 120 days. MMCC provider contracts required claims to be submitted within 120 days from the date of service. MMCC did not deny the claims for exceeding timely filing requirements. MMCC indicates the timely filing edit was overridden because the claims were timely received by MMCC's electronic data interface (EDI) claims vendor. Problems occurred with the transmission of the EDI claims from the vendor to MMCC. Providers were allowed to resubmit the claims after the 120 day timely filing limit. (See Section VII.F.)

2. For five claims tested where the enrollee has copayment responsibilities, MMCC did not properly accumulate copayments incurred on two claims. (See Section VII.H.)

3. MMCC should improve claims inventory control procedures to include a reconciliation that ensures that all claims received, either in the mailroom or electronically, are processed by the claims system or properly returned to the provider. (See Section VII.M.)

4. MMCC should improve claims inventory control procedures to ensure that all claims sent to MMCC's vendor for the electronic scanning of claims, Health Solutions Plus, Inc. (HSP), are reconciled to the number of scanned claims returned from the vendor. (See Section VII.M.)

5. The following deficiencies were noted during the review of the claims payment accuracy report preparation procedures (See Section VII.C.):

   - Claims were not randomly selected by MMCC from a defined population.

   - The number of claims selected for testing by MMCC was not sufficient to project the results to the entire population.

   - Only paper submitted claims were selected by MMCC for testing. Electronically submitted claims were not tested.

   - MMCC reported 99.3% accuracy for the second quarter 2003; however, when the claims were tested by TDCI and the Comptroller, three claims considered correctly paid by MMCC were incorrectly paid, reducing the accuracy rate to 96%. The Contractor Risk Agreement requires 97% claims payment accuracy.

   - Additionally, for four correctly paid claims to the same provider, the provider's billed charges equaled the contracted rate. However, it was determined that the fee table logic in the claims system did not correctly reflect the contracted rates. MMCC should review all contracts to ensure the fee table logic in the claims processing system agrees with the contracted rates.

6. MMCC was not in compliance with prompt pay requirement of Tenn. Code Ann. §56-32-226(b) for claims processed during July 2003. Additional testing concluded MMCC had obtained prompt pay compliance for August 2003. (See Section VII.A.)

C. Compliance Deficiencies

1. TDCI and the Comptroller requested MMCC provide any changes to reimbursement rates and policies since April 16, 2002. MMCC provided correspondence to the TennCare Bureau requesting approval for changes to reimbursement rates. For two of eleven requests for changes to reimbursement rates, a corresponding TennCare Bureau approval was never provided. MMCC

contends that for the unapproved changes to the reimbursement rates, the resulting changes were cost beneficial to the TennCare Program. (See Section VIII.H.)

2. For the 12 provider complaints selected for testing, MMCC did not properly respond to three complaints. (See Section VIII.A.)

3. Three provider agreements selected for testing did not contain all provisions required by Section 2-18. of the Contractor Risk Agreement. (See Section VIII.C.)

4. MMCC lacks an internal audit function as part of MMCC's organizational structure. (See Section VIII.F.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, MMCC is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if MMCC meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2003, MMCC reported $13,328,978 in admitted assets, $2,243,551 in liabilities and $11,085,429 in capital and surplus on its NAIC quarterly statement. MMCC reported total net income of $7,942,742 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires MMCC to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2003 Statutory Net Worth Calculation

MMCC's premium revenue per documentation obtained from the TennCare Bureau totaled $346,804,717 for the calendar year 2002; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), MMCC's statutory net worth requirement for the calendar year 2003 is $8,952,071. MMCC reported total capital and surplus of $11,085,429 as June 30, 2003, which is $2,133,358 in excess of the minimum statutory net worth requirement. See the effect of the examination adjustments to net worth in paragraph E. of this Section of the report.

Premium Revenue for the Examination Period

The following is a summary of MMCC's premiums for the six months ended June 30, 2003, as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from TennCare For the period January 1 through June 30, 2003	$11,504,329.66
Reimbursement for medical payments from TennCare For the period January 1 through June 30, 2003	186,956,030.94
Reimbursement for premium tax payments from TennCare For the period January 1 through June 30, 2003	4,367,776.29
Prior year capitation payments from TennCare For the period before May 1, 2003	245,222.53
Total premium revenue	$203,073,359.42

2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and (3) requires all HMOs licensed in the state to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any other federal law adopted by amendment to the required Title XIX state plan."

Based upon premium revenues for calendar year 2002 totaling $346,804,717, MMCC's statutory deposit requirement at June 30, 2003, is $2,950,000. MMCC has on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $2,955,000 have been pledged for the protection of the enrollees in the State of Tennessee.

3. <u>Claims Payable</u>

As of June 30, 2003, MMCC reported $135,451 in claims unpaid on the NAIC quarterly statement. This amount represented an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending April 30, 2002. Review of claims processing system payments after June 30, 2003, through August 31, 2003, for dates of services before May 1, 2002, indicates payments of $46,389. Therefore, MMCC's claims unpaid as reported on the June 30, 2003, NAIC Quarterly Financial Statement appears reasonable.

4. <u>Interest Earned on State Funds</u>

Section 3-10.h.2.(d) of the Contractor Risk Agreement states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. As of the examination fieldwork date, MMCC had not remitted to the State any interest earned on deposits for provider payments related to the non-risk agreement period. It was determined that $137,317 of interest earned was due to the State for the non-risk period from May 1, 2002, through June 30, 2003. MMCC's capital and surplus will be adjusted to reflect a payable as of June 30, 2003, to the State in the amount of $137,317. (See the effect of examination adjustments to net worth in paragraph E. of this Section of the report.) After the completion of examination fieldwork, MMCC refunded the interest earned to the State. As interest is earned monthly, MMCC should reduce the next medical reimbursement request to the TennCare Bureau for the interest earned.

Management's Comment

Management concurs with the recommendation and has changed its procedures to reflect this finding.

5. Recovery Amounts/Third Party Liability

Section 3-10.h.2.(f) of the Contractor Risk Agreement requires third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau. As of August 2003, MMCC reported in the account "Claims Advance Payable" a balance of $1,457,280. The account included third party recoveries, subrogation, and claims payment recoupments. As of the examination fieldwork date, MMCC had not remitted any of these amounts to the State. After the completion of examination fieldwork, MMCC refunded to the State the third party liability recoveries and subrogation amounts previously received related to the non-risk period. As third party liability and subrogation amounts are recovered, MMCC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered.

Management's Comment

Management concurs with the recommendation and has changed its procedures to reflect this finding.

6. Cash and Receivable Classification Error

MMCC incorrectly recorded as cash on the 2003 NAIC Annual Statement a receivable due from the TennCare bureau of $9,684,089. The classification error did not affect MMCC's reported net worth as of June 30, 2003.

Management's Comment

Management agrees to the change as required by TDCI and to the comment that the change has no effect on statutory net worth. The financial statements were prepared recognizing the month end timing difference between the funding request to TennCare and the check date on the provider checks.

7. Receivables Due From Parent, Affiliates, and Subsidiaries

MMCC incorrectly included in admitted assets $17,095 in receivables from parents, subsidiaries, and affiliates over 90 days old on the June 30, 2003, Quarterly NAIC Statement. MMCC's capital and surplus will be reduced by this amount. Per Tenn. Code Ann. § 56-32-212(5)(D) admitted assets include receivables that are not more than ninety days past due. See the effect of examination adjustments to net worth in paragraph E. of this Section of the report.

Management's Comment

Management agrees with the finding as stated.

B. Administrative Services Only (ASO)

As previously mentioned, effective May 1, 2002, MMCC's Contractor Risk Agreement was amended so that MMCC would operate as an ASO until December 31, 2003. Under the NAIC guidelines for an ASO, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for MMCC for dates of service after April 30, 2002.

It should be noted that the Contractor Risk Agreement requires a deviation from ASO guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if MMCC were still operating at-risk. As stated in section 2-10.i. of the Contractor Risk Agreement, MMCC is to provide "an income statement addressing the TennCare operations." TennCare HMOs provide this information on the Report 2A.

On MMCC's supplemental TennCare Operations Statement of Revenues and Expenses Report 2A for the six months ended June 30, 2003, MMCC reported $200,039,792 as total revenue, $184,233,682 as total medical and hospital expenses, $7,863,368 as total administration expenses, and $7,942,742 as net income. However, MMCC did not prepare the TennCare Operations Statement as if MMCC were still at risk, because it did not include an accrual for IBNR in medical expenses and the related premium accrual in total revenue. Section 2-10.i. of the Contractor Risk Agreement requires all income and expenses related to claims, losses, and premiums for claims with dates of service after May 1, 2002, to be included in the TennCare Operations Statement. The deficiencies in preparing Report 2A did not affect MMCC's reported net worth or net income; however, Report 2A should present MMCC's operations as if MMCC were still at risk.

Management's Comment

Management agrees that the noted deficiencies did not affect MMCC's reported statutory net worth or net income. Management had previously adjusted its reporting practices as noted. Management would appreciate TDCI recommend revised language to the Bureau of TennCare for insertion into the CRA to more clearly state the reporting requirements.

C. Medical Fund Target

Effective July 1, 2002, the Contractor Risk Agreement requires MMCC to submit a Medical Fund Target (MFT) on a monthly basis. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. MMCC submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for IBNR expenses have been reviewed for accuracy. No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Fund Target report.

D. Release of Subordinated Payables

As of December 31, 2002, MMCC reported a subordinated payable balance of $4,750,516. The establishment of subordinated payable was approved by TDCI on August 13, 1999, in order to correct a previous net worth deficiency by MMCC. The subordinated payable represents previously unpaid medical bills to MMCC's affiliate, The Med. Release and payment of the subordinated payable requires the prior approval of TDCI. During the examination period January 1, 2003, through June 30, 2003, MMCC received approval from TDCI for the release and payment of $1,855,092 of the subordinated payable balance. The remaining subordinated payable balance was $2,895,424 at the end of the examination period June 30, 2003. By September 30, 2003, MMCC had received approval from TDCI for the release and payment of the remaining subordinated payable balance.

E. Schedule of Examination Adjustments to Capital and Surplus

Capital and surplus as reported on the NAIC quarterly statement at June 30, 2003	$11,085,429
Less: Interest payable	137,317
Less: Non-admitted receivable	17,095
Adjusted capital and surplus	$10,931,017
Required statutory net worth	8,952,071
Excess statutory net worth	$ 1,978,946

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the Contractor Risk Agreement. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other

appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI previously requested data files from all TennCare MCOs containing all claims processed during the months of January 2003, April 2003, and July 2003. Because of the lag between the date of service and the date the claims are received and processed, the dates of services for claims processed during the month of July 2003, are relevant to the examination period. Separate files were submitted for medical and pharmacy claim types. As previously mentioned, MMCC was not contractually responsible for pharmacy benefits as of July 1, 2003. Each set of data was tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. § 56-32-226(b)(1). Because these tests were performed on all claims processed in January 2003, April 2003, and July 2003, no projection of results to the population is needed. Listed below are the results of the analyses for medical claims:

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	94.3%	99.8%	**Yes**
April 2003	97.3%	99.9%	**Yes**
July 2003	81.2%	99.4%	**No**

Listed below are the results of the analyses for pharmacy claims:

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	100%	100%	**Yes**
April 2003	100%	100%	**Yes**

MMCC processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements for the months of January 2003, and April 2003. However, MMCC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) the month of July 2003.

As a result of the failure to meet prompt pay compliance in July 2003, TDCI requested an additional data file for all claims processed in August 2003. Listed below are the results of the August 2003 analysis:

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
August 2003	96.8%	99.1%	**Yes**

The levy of an administrative penalty and additional data file requests were not made since MMCC was found in compliance with Tenn. Code Ann. § 56-32-226(b)(1) for the month of August 2003.

Management's Comment

Management agrees with the finding. MMCC would like to note that it failed to meet the July prompt pay compliance due to a Summer Storm that caused wide spread electrical failures that extended for over 5 business days.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on MMCC's claims processing system.

The following items were reviewed to determine the risk that MMCC had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints on file with TDCI related to accurate claims processing
- MMCC's monitoring procedures for subcontractors
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls

As noted below, TDCI and the Comptroller discovered several deficiencies related to the claims accuracy testing by MMCC. Also noted in Section VIII.F. of this report, MMCC lacks an internal audit function as part of the organization structure. Therefore, substantive testing was expanded beyond the initial 60 claims selected for testing. Expanded test work included verification of the 99 claims previously tested in MMCC second quarter 2003 claims payment accuracy report.

C. Claims Payment Accuracy Report

Section 2-9. of the Contractor Risk Agreement requires that 97% of claims are paid accurately upon initial submission. MMCC is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

MMCC reported the following results for the first and second quarters of 2003:

	# of claims tested	Results Reported	Compliance
First Quarter 2003	99	100%	**Yes**
Second Quarter 2003	99	99.3%	**Yes**

1. Procedures to Review the Claims Payment Accuracy Reporting

   The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter claims payment accuracy report. This review included verification that the number of claims reviewed constituted an adequate sample to represent the population.

   In addition, claims were selected at random by TDCI and the Comptroller from the MCO's second quarter 2003 claims payment accuracy report. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

   The quarterly claims accuracy report for the second quarter of 2003 was selected for review. As previously mentioned, all 99 claims in MMCC's sample were tested for payment accuracy. MMCC provided supporting documentation for this report. The following deficiencies were noted in the claims payment accuracy report:

- Claims were not randomly selected by MMCC from a defined population.

- The number of claims selected for testing by MMCC was not sufficient to project the results to the entire population.

- Only paper submitted claims were selected by MMCC. Electronically submitted claims were not tested.

- MMCC reported 99.3% accuracy for the second quarter 2003; however when the claims were tested by TDCI and the Comptroller, three claims considered correctly paid by MMCC were incorrectly paid, reducing the accuracy rate to 96%. The Contractor Risk Agreement requires 97% claims payment accuracy.

- Additionally, for four claims correctly paid to the same provider, the provider's billed charges equaled the contracted rate. However, it was determined that the fee table logic in the claims system did not correctly reflect the contracted rates. MMCC should review all contracts to ensure the fee table logic in the claims processing system agrees with the contracted rates.

Management's Comment

MMCC's system has been updated with specific fees for the transportation services provided in accordance with the provider agreements as of July 1, 2004 for all transportation vendors.

MMCC began during the audit and continues with a contract review process to ensure the fee table logic in the claims processing system agrees with the contracted rates.

MMCC has reviewed its claims audit practices and made the requisite changes to assure random selection, size of sample reflects entire population, and that all claims both paper and electronic be tested.

D. Claims Selected For Testing From Prompt Pay Data Files

Sixty additional claims were selected from the January 2003 and April 2003 prompt pay data files previously submitted to TDCI. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment. From each data file, 30 claims were randomly selected.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by MMCC.

To ensure that the January 2003 and April 2003 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in MMCC's claims processing system. Attachment XII of the Contractor Risk Agreement lists the minimum required data elements to be recorded from medical claims and submitted to TennCare as encounter data. Original hard copy claims were requested for the 60 claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into MMCC's claims processing system. No discrepancies were noted between the information submitted on the claims and the data recorded in MMCC's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

For 29 of the 60 claims selected for testing, the difference between the date of service and the received date exceeded 120 days. MMCC provider contracts required claims to be submitted within 120 days from the date of service. MMCC did not deny the claims for exceeding timely filing requirements. MMCC indicates the timely filing edit was overridden because the claims were timely received by MMCC's electronic data interface (EDI) claims vendor. Problems occurred with the transmission of the EDI claims from the vendor to MMCC. Providers were allowed to resubmit the claims after 120 day timely filing limit.

Management's Comment

It has been MMCC's practice and MMCC has since formally developed a policy that permits a provider to resubmit a claim that exceeded the timely filing requirements due to third party error (See Attachment I for MMCC's Policy Timely Filing).

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

From the 60 claims selected for testing, the paid amount for ten claims was compared to amounts required by the provider's contract. All ten claims were paid in accordance with the contracted rates.

H. Copayment Testing

The purpose of testing copayment is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated in accordance with Section 2-3.k. of the Contractor Risk Agreement.

For five claims tested where the enrollee has copayment responsibilities, MMCC did not properly accumulate copayments incurred on two claims.

Management's Comment

Management has tested the claims system and confirms that since system reconfiguration in November, 2002 that the accumulators are working. The claims in question were paid in May, 2002 at a time during which Management agrees that the accumulators were not working satisfactorily.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested remittance advices for five of the 60 claims selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by MMCC; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for the five claims which were also selected for remittance advice testing. Cancelled checks were provided by MMCC. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The previously submitted April 30, 2003, pend file was selected for testing. At April 30, 2003, MMCC had 94,466 medical and pharmacy claims in a pend status. The received date for 6,122 claims was greater than 60 days as of April 30, 2003. The number of pended claims over 60 days old represents 6.4% of total pended claims at April 30, 2003. Review of the pended claims does not indicate an unrecorded liability exists since most of the claims in pend status represented dates of service after May 1, 2002, the beginning of the non-risk period.

L. Electronic Claims Capability

Section 2-9.g. of the Contractor Risk Agreement states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment …" The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

MMCC has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by MMCC ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system.

- MMCC does not reconcile the total number of paper and electronically submitted claims to the total number claims processed by MMCC's claims processing system and claims properly returned to the provider. MMCC should improve claims inventory control procedures to include a reconciliation that ensures that all claims received, either in the mailroom or electronically submitted, are either processed by the claims system or properly returned to the provider.

- A log is not maintained for claims sent to HSP, the vendor for scanning claims into an electronic format. MMCC does not reconcile the number of claims sent to HSP to the number of claims HSP returns to MMCC as scanned images. MMCC should improve claims inventory control procedures to ensure that all claims sent to HSP agree to the number of scanned claims returned from the vendor.

Management's Comment

Management agrees paper claims were sent to HSP without adequate processes to assure that no claims were lost. At the present time no paper claims are sent to HSP. The new inventory control system, currently under development, will establish the controls recommended by this audit.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

Provider complaints were tested to determine if MMCC properly responded to all provider complaints. Twelve complaints were selected from MMCC's customer service report. MMCC properly responded to five provider complaints. MMCC did not properly respond to two provider complaints tested.

Management's Comment

Management agrees that in two (2) instances proper responses were not documented in our Customer Services tracking reports. Due to the documentation errors identified, new processes have been established to ensure proper documentation and responses of all complaints in TLC's Customer Services Systems and Reports.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. A review of MMCC's Policy and Procedure Manual revealed no weaknesses.

Management's Comment

On going education – MMCC provider relation's associates work daily with our providers in explaining both MMCC and TennCare policies and procedures.

Retooling Provider Manual – MMCC is committed to the concept of continuous improvement and while no deficiencies were cited, MMCC is in the final stages of updating its manual, which is designed to improve both it usability and promote consistency.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include but are not limited to; standards of care, assurance of TennCare enrollees rights, compliance with all Federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the Contractor Risk Agreement between MMCC and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the Contractor Risk Agreement requires that all provider agreements executed by MMCC shall at a minimum meet the 44 current requirements listed in Section 2-18.

Three provider contracts were reviewed to determine compliance with Section 2-18. of the Contractor Risk Agreement. The provider contracts represented the following provider types: hospital, specialty, and ancillary. The following sections were not found for all three provider contracts tested:

f. Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient under this Agreement for non-medical reasons, including, but not limited to, failure to pay applicable cost sharing responsibilities. Upon next renewal of provider agreements, the CONTRACTOR shall specify that effective January 1, 2003, the CONTRACTOR may require that a TennCare Standard enrollee pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, until such time that an amendment to the provider agreements are executed, the CONTRACTOR shall include said provisions in the providers' administrative manual or other such communications. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

oo. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare; and

pp. Specify that in the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the MCO's contracted reimbursement rate or the rate established by TENNCARE, whichever is greater.

The following sections were found to be missing from only the specialist contract tested:

cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

ll. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules, subsequent amendments, or any and all Court Orders.

MMCC did not amend provider agreements to include all of the Contractor Risk Agreement requirements of Section 2-18.

Management's Comment

MMCC is currently working with TDCI to bring our provider agreements into full compliance with the current Contractor Risk Agreement. Once approval is received on the Primary Care Case Manager agreement, the Specialty, Ancillary, and Hospital agreements will be filed. Once all approvals are received, TLC will be executing new agreements with our providers accordingly to comply with all contract language provisions.

D. Subcontracts

During the examination period, Scrip Solutions was subcontracted by MMCC to provide pharmacy benefits. The Scrip Solutions contract was terminated effective July 1, 2003. At that time, the TennCare Bureau assumed responsibility for pharmacy services.

E. Title VI

Effective July 1996, Section 2-25 of the Contractor Risk Agreement required MMCC to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various MMCC staff and a review of policies and related supporting documentation, MMCC was in compliance with Section 2-25 of the Contractor Risk Agreement.

F. Lack of Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

During the examination of MMCC, it was noted that MMCC lacks an internal audit function as part of MMCC's organizational structure. As previously noted, MMCC received TennCare premium revenues of $346,535,307 for calendar year 2002 and $203,073,599 for the period January 1, 2003, through June 30, 2003. The significant amount of premiums received would warrant the employment of at least one internal auditor by MMCC. Also, the examination has discovered significant deficiencies which could have been avoided with a properly functioning internal audit department. These deficiencies include: incorrect fee tables loaded into the claims processing system, no procedures in place to ensure all claims received were processed or returned to providers, and deficiencies in the claims payment accuracy reporting.

Management's Comment

Management has this recommendation under review. It is uncertain whether an internal audit function would have assured that the deficiencies noted in this report would have been avoided.

G. Behavioral Health Organization (BHO) Coordination

MMCC was in compliance with Section 2-3.c.2 of the Contractor Risk Agreement whereby effective July 1, 2002, “claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx’’ are submitted to MMCC for timely processing and payment.

MMCC is required to refer unresolved disputes between the HMO and BHO to the State for a decision on responsibility after providing medically necessary services. MMCC did not have any ongoing disputes with the BHO.

Management’s Comment

Management wishes to note that despite its best efforts it has been unable to establish a consistent communication channel and case management coordination with the BHO.

H. Stabilization

Section 2-2.s. of Amendment 3 of MMCC’s Contractor Risk Agreement requires MMCC to comply with the following:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as they existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for the purpose of documenting medical management policies and procedures before final execution of this Amendment.

TDCI and the Comptroller requested MMCC provide any changes to reimbursement rates and policies since April 16, 2002. MMCC provided correspondence to the TennCare Bureau requesting approval for changes to reimbursement rates. For two of eleven requests for changes to reimbursement rates, a corresponding TennCare Bureau approval was never provided. MMCC contends that for the unapproved changes to the reimbursement rates, the resulting changes were cost beneficial to the TennCare Program. MMCC did not receive approval for the following changes to reimbursement rates:

Date Requested	Type of Provider	MMCC Comments
June 7, 2002	Dental	Yes, but are cost neutral
June 7, 2002	Physicians	Partially implemented – Primary Care and Specialty Care outside Shelby County implemented and cost savings resulted.

Management's Comment

Management agrees with the finding as stated.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of MMCC.

Management Comment

MMCC and its associates wish to thank the Department for providing such a valuable service, regardless of the statutory requirements, to our company. The discussions and perspective shared are valuable aids to our efforts to improve our performance.

Attachment I

MEMPHIS MANAGED CARE CORPORATION
TLC FAMILY CARE HEALTHPLAN

CLAIMS DEPARTMENT POLICY

POLICY: Timely Filing Limit

PURPOSE: To consistently enforce timely filing guidelines and limitations for claims adjudication.

APPROVED BY: ____

RESPONSIBILITY: Claims Services Department

SCOPE: Claims, Customer Services, and Provider Relations, Information Systems/EDI

Procedure:
Participating and non-participating providers must submit all claims for medical services within 120 Days of the date of service or for inpatient services, within 120 days from the date of discharge. In the case of retroactive TLC eligibility determinations, 120 days will still be the allotted time from the create date that is supplied by the Bureau of TennCare via eligibility tape updates.

> **Example:** Eligibility for 4/15/2000, TennCare enrollment tape updated on 2/12/2000, eligibility retro 120 days from the date TLC created the update to the received date of the claim.

TLC will not be obligated to pay claims filed after the expiration of the applicable time period. The TLC enrollees are not responsible for charges filed after the 120-day filing period. If TLC is secondary to a commercial insurer or Medicare, claims must be submitted within 120 days from the date the primary insurers remittance advice was produced.

> **Denial Reason Code: TIME- Claim must be filed within 120 days from the date of services.**

Acceptable Forms of Proof of Timely Filing:

1. **A dated roster itemizing each claim submitted. The roster must be one that has been verified by a Claims Services Associate and returned to the provider prior to submission of a timely filing request.**

2. **A signed certified post office delivery receipt, or any other Special Delivery receipt (example: *FedEx, UPS*) along with a dated roster itemizing each claim. The roster must be one that has been verified by a Claims Services Associate and returned to the provider prior to submission of a timely filing review request.**

3. **A TLC electronic data interchange (EDI) confirmation of receipt of claims report.**

Procedure for EDI Claims Issues between Provider, Clearinghouse and TLC

There are times when a provider may experience an issue related to the transmission of claims via their clearinghouse that is not the fault of the provider or TLC. In such instances, TLC may waive timely filing requirements, at TLC's sole discretion provided the following:

- **TLC was previously notified of the problem with the clearinghouse.**
- **The provider has proof of submission of said claims to the clearinghouse. Proof must include a confirmation of receipt by the clearinghouse.**
- **A definitive timeframe of the occurrence of the issue (i.e., a beginning and ending date time span).**

In order to have these claims processed without the timely filing limitation applied, the provider must submit all claims in a single batch submission to TLC. Further, the provider must coordinate this resubmission with I.S./eCommerce, Provider Relations, Customer Service and or Claims Department of TLC Family Care Health Plan.

Once the single batch/submission mentioned above has been received, the provider may not submit additional claims to TLC related to the same issue. It is imperative the provider submits <u>ALL</u> affected claims in the single batch/submission.